STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445321	A. BUILDING _____ B. WING _____	C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDMORE HEALTH AND REHABILITATION CENTER	25385 MAIN STREET ARDMORE, TN 38449

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F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: During the complaint investigation of # 35117, # 35502 and # 36016, conducted on June 29-30, 2015, at Ardmore Health and Rehabilitation Center, deficiencies were cited in relation to complaint # 35502 and # 36016 under 42 CFR PART 483, Requirements for Long Term Care Facilities. Complaint # 35117 was not substantiated . Based on the facility investigation review, resident and staff interviews and medical record review, the facility failed to protect two of six residents reviewed for abuse. Resident #1 was admitted to the facility on 9/28/2014 with diagnoses including Dementia with Behavior Disturbance, Bipolar Disorder, Generalized Anxiety, Intellect Disability, Dizziness and Giddiness, Hepatic Encephalopathy, TIA/Stroke, Muscle weakness-General, Abnormality of Gait, Diabetes Mellitus II and Intellect Disability. Review of the Minimum Data Set (MDS) dated 8/22/2014 revealed a Brief	F 223	This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F223 **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. The Residents that were identified to be affected by abuse were protected by the facility by removing the threat immediately by suspending the accused, following our abuse policy, and reviewing our current policy and educational requirements for effectiveness.	7-22-2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brandon Whitesell | Administrator | 7-23-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 Interview for Mental Status (BIMS) score of 15 (cognitively intact). Review of the Facility Investigative Summary for this complaint revealed Resident # 1 had reported on 3/2/15 that she had an issue with one of the nurses and provided a description of the nurse. The resident chose to file a grievance and reported to the Social Worker that she had asked for her medication and that the nurse stated it was not time and did not give it to her. Continued review revealed the nurse followed the resident into the dining room and confronted the resident in front of other residents. The resident reported that she was fearful of the nurse. The nurse was suspended immediately. Witness statements of the exchange were taken by the facility. The facility did not substantiate abuse; however, the nurse was terminated by the facility for violation of resident ' s rights. Multiple observations of Resident #1 on 6/29/15 and 6/30/15 revealed the resident sat on the seat of her walker across from the nurse ' s station most of the day, attended activities and watched her television. Interview on 6/29/2015 at 12:50 PM with Resident #1 in the resident ' s room revealed the resident stated she had never been abused, yelled at or been in an argument with staff or other residents in this facility. She also stated she had not seen any other resident or staff being abused. Continued interview with Resident # 1 revealed she " was told if she saw any resident or staff being abused to report it to the nurse or administrator. "	F 223	**How will the facility identify other residents having the potential to be affected by the same deficient practice?** 2. Additional education will be provided on an annual basis in the form of two modules: Preventing, Recognizing, and Reporting Resident Abuse for the month of March. Abuse and Neglect Fundamentals for the month of August. The modules will be added to the three current modules: Abuse Prevention/ Reporting Policy and Procedure in the month of June. Abuse Policy- Elder Justice Act in the month of January. Resident Rights In-Service in the month of September. 100% of our staff will be in serviced on recognizing and reporting abuse by 7-22-2015. With the training that is scheduled and the in-services that will be completed I believe our staff will thoroughly understand how to recognize, prevent, and report abuse effectively.	

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F 223	Continued From page 2 Interview on 6/30/15 at 1:30 PM with the Social Services Director in the Admissions Office revealed " I spoke with Faye after the incident and she said that she had been embarrassed when the nurse came into the dining room and confronted her in front of the other residents. " Interview on 6/30/15 at 1:30 PM with the Administrator in the Administrator ' s office revealed " When an incident of abuse or suspected abuse is reported, we immediately begin investigating it. The nurse was suspended pending the outcome and was ultimately terminated. " Telephone interview on 7/2/15 at 1:55 PM with CNA#7 revealed when read her witness statement provided by the facility " (Resident # 1) was up at the front desk asking about her medicine that was due at noon and it wasn ' t even noon yet as I was coming around the front desk with (named resident) to place her in the dining room. (Resident # 1) was behind me mumbling and sat down in her normal spot and I was setting (named resident) tray up and LPN #5 (the nurse) came in there talking to (Resident # 1) telling her she was the nurse and she knows when her medicine is due and she will get it for her when it is time. I don ' t remember what else was said but (Resident # 1) got smart back " CNA #7 stated, in response to being read her written statement, " That is how I remember it. " Attempted telephone interview on 7/9/15 at 10:00	F 223	**What measures will be put into place or systemic changes made to insure that the deficient practice will not recur?** 3. Additional educational modules will be provided to reduce the gaps in Abuse Training throughout the year. The educational modules that we have selected will serve as a deterrent, and will encourage the proper recognition and reporting of abuse. We will also continue to follow our Abuse policy as stated in the statement of deficiencies, for every allegation of abuse to prevent and deter reoccurrence. **How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?** 4. Allegations of Abuse will be discussed and tracked in our Quality Assurance Performance Improvement meetings which include: The Administrator, DON, Medical Director, ADON, Unit Manager, Maintenance Director, Social Services, Activities Director, Food Services Manager, Medical Records, Human	

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F 223	Continued From page 3 AM with LPN #5 (terminated employee). Family member answering the telephone reports " her only child, 5 years old, was ejected from an automobile yesterday. He is brain dead and being removed from life support today. " Review of Social Service Progress Notes dated 3/2/2015 revealed " ... Resident approached this writer & (and) says one of the nurses over the weekend /Sunday was mean to her ... she told the nurse she wanted her pills at 12 & it was 1 before she got them ... she asked this same nurse she (nurse) said she was not going to take this from you (resident) ...says the nurse started all this & was mean to her & she didn ' t do anything. " Review of Social Service Progress Notes dated 3/3/2015 revealed " ...Resident says she was sitting in the dining room (DR) & the nurse came in the DR while she was eating & (and) told her she wasn ' t going to take this from her ... says nurse raised her voice & everybody was in the dining room ...says she doesn ' t like being jumped on, that she cried ... " Review of Nurses Notes dated 3/1/2015 at 11:30 AM written by LPN # 5(the terminated employee) revealed " ...the resident raises her voice saying that she wants her medicine ...the resident walks away and goes to the dining room for lunch. This nurse went into the dining room and told the resident that this nurse did not appreciate being yelled at and that this nurse has never yelled at the resident ... "	F 223	Resources, Business Office Manager, Admissions Director, and other staff members as necessary monthly as an ongoing standing agenda item. If an allegation is identified our policy will be followed and the policy will be reviewed for effectiveness by the Quality Assurance Performance Improvement team, if changes or amendments are needed the policy will be updated.	

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F 223	Continued From page 4 Resident #2 was admitted to the facility on 4/8/2014 with diagnoses including Above the Knee Amputation, Muscle Weakness, Symbolic Dysfunction, Osteomyelitis, Gangrene, Diabetes Mellitus II, Neuropathy, Chronic Kidney Disease Stage III, and Dementia. The resident had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Observations, resident and staff interviews and review of the resident ' s MDS, Care Plans, and Clinical Notes revealed no areas of concern regarding Abuse. Review of the Facility Investigation dated 1/23/2015 revealed the allegation of abuse was validated and confirmed the allegation. Upon receiving the report, the facility immediately placed the employee on suspension. Further facility investigation substantiated the claim. The employee was terminated on 1/23/2015. Review of the facility investigation report revealed the facility followed their Abuse Policy/Protocol. No concerns were identified. Multiple observations of Resident #2 and interactions between the resident and staff on 6/29/15-6/30/15 revealed no area of concern. Interview attempted on 6/30/2015 at 9:35AM with Resident #2 in the resident ' s room revealed resident to be non-interviewable. Resident was clean, dry, and in bed resting. Interview on 6/30/15 at 9:50 AM with CNA # 2 in the Admissions Office revealed " We went to change (Resident # 2). She can assist in turning if you are patient with her. (Terminated Employee)	F 223		

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F 223	Continued From page 5 wasn ' t patient and turned her quickly. (Resident # 2) arm was in the rail and got caught. " When asked about Resident # 2 ' s response to the incident, CNA # 2 stated " She cried out ' Ow, that hurt! ' " Interview on 6/30/2015 at 1:10PM in the Admission Office with LPN#2 revealed Resident #2 could assist with turning when she was given the time to do so. Interview on 6/30/15 at 1:30 PM with the Administrator in the Administrator ' s office revealed " When an incident of abuse or suspected abuse is reported, we immediately begin investigating it. The CNA was suspended pending the outcome and was ultimately terminated. " Telephone interview on 7/2/15 at 10:10 AM with Registered Nurse # 1 revealed " I didn ' t see it when it happened. The CNA called me to the room about the skin tear ... I went immediately and reported it to the DON. " Attempted telephone interview on 7/2/15 at 10:20 AM with CNA # 6. There was no answer and a voicemail was left.	F 223		